



**CITY OF SOMERVILLE  
ISD/HEALTH DIVISION  
1 FRANEY ROAD  
SOMERVILLE, MA 02145  
(617) 625-6600 EXT. 4330**

**APPLICATION FOR BODY ART PRACTITIONER LICENSE**

License filing fee of \$300 submitted: Yes \_\_\_\_\_ No \_\_\_\_\_

Applicant's Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

Home Address: \_\_\_\_\_

No. Street

Town/City

State

Zip Code

Home Phone Number: \_\_\_\_\_ Business Phone Number: \_\_\_\_\_

Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

No. Street

Town/City

State

Zip Code

Emergency Response Person: \_\_\_\_\_ Telephone: \_\_\_\_\_

All residential addresses of applicant for the past five (5) years:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D.O.B.: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hair color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Proof of age (copy of birth certificate or driver's license) submitted: Yes \_\_\_\_\_ No \_\_\_\_\_

Two (2) front faced portrait photographs (2"x 2") within six (6) months submitted: Yes \_\_\_\_\_ No \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Type of Body Art to be practiced: Body Piercing (only) \_\_\_\_\_

Tattooing, Branding and Scarification (only) \_\_\_\_\_

Both \_\_\_\_\_

What education, training and experience have you had to qualify you to practice Body Art?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Diploma and transcript received: Yes \_\_\_\_\_ No \_\_\_\_\_

**Body Art Practitioner License****(2)**

Former occupations or Body Art occupations of applicant for past three (3) years:

**Occupation****Name of Business and Address**

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At what place or places do you wish to be licensed to practice Body Art?

**Business Name****Address**

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Have you had a license or permit to practice Body Art suspended or revoked by any agency or board, city, county or state? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, explain:

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List all criminal convictions, forfeiture of bond, or plea of nolo contendere, excluding traffic, misdemeanor or infraction violations:

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I authorize and release the Board of Health to seek information or references necessary to verify the information contained in this application:

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**Signature of Applicant**

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**Date**

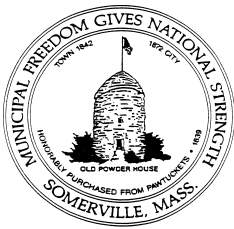
I certify under penalty of perjury that all information contained in this application is true and correct. Any misstatements in this application are grounds for refusing to issue or for revocation of any license issued.

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**Signature of Applicant**

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**Date**



**CITY OF SOMERVILLE  
ISD/HEALTH DIVISION  
1 FRANEY ROAD  
SOMERVILLE, MA 02145  
(617) 625-6600 EXT. 4330**

**APPLICATION FOR BODY ART FACILITY LICENSE**

License filing fee of \$400 submitted: Yes\_\_\_\_\_ No\_\_\_\_\_

Business Name:\_\_\_\_\_

Business Address: \_\_\_\_\_

No. Street

Town/City

State

Zip Code

Applicant's Full Name:\_\_\_\_\_ Date:\_\_\_\_\_

Home Address: \_\_\_\_\_

No. Street

Town/City

State

Zip Code

Home Phone Number:\_\_\_\_\_ Business Phone Number:\_\_\_\_\_

Name of Owner (if different from applicant):\_\_\_\_\_

If a corporation or partnership, please give name, title, and home address of officers, partnerships, stockholders with 10% or more of the stock. Supplemental Information pages must be submitted for each individual.

<b>Name</b>	<b>Title</b>	<b>Home Address</b>	<b>Home Telephone</b>
_____	_____	_____	_____
_____	_____	_____	_____

Emergency Response Person:\_\_\_\_\_ Telephone:\_\_\_\_\_

State of Incorporation:\_\_\_\_\_

Federal Identification Number:\_\_\_\_\_

All residential addresses of applicant for the past five (5) years:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D.O.B.:\_\_\_\_\_ Sex:\_\_\_\_\_ Height:\_\_\_\_\_ Weight:\_\_\_\_\_ Hair Color:\_\_\_\_\_ Eye Color:\_\_\_\_\_

Proof of age (copy of birth certificate or driver's license) submitted: Yes\_\_\_\_\_ No\_\_\_\_\_

Two (2) front faced portrait photographs (2"x 2") within six (6) months submitted: Yes\_\_\_\_\_ No\_\_\_\_\_

Social Security Number:\_\_\_\_\_

## Body Art Facility License

(2)

Articles of corporation or partnership submitted: Yes \_\_\_\_\_ No \_\_\_\_\_

Type of Body Art to be practiced: Body Piercing (only) \_\_\_\_\_

Tattooing, Branding and Scarification (only) \_\_\_\_\_

Both \_\_\_\_\_

Facility Hours of Operation: \_\_\_\_\_

Number of full or part time Body Art practitioners: \_\_\_\_\_

Former occupations or Body Art occupations of applicant for past three (3) years:

**Occupation**

**Name of Business and Address**

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Have you had a license or permit to practice Body Art or conduct a Body Art Establishment suspended or revoked by any agency or board, city, county, or state?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain:

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List all criminal convictions, forfeiture of bond, or plea of nolo contendere, excluding traffic, misdemeanor or infraction violations:

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Provide the following:

- A. Scaled plans and specifications of the proposed facility to demonstrate compliance with the Body Art Ordinance at time of original application and upon any change in facility layout.
- B. Present original and provide copy of Business Certificate issued by the City Clerk under the provisions of MGLc. 110 § 5.
- C. Copy of Client Applications and Consent Form for Body Art to be used within the Facility.
- D. Copy of Aftercare Instructions to be used by all practitioners within the Facility.
- E. Name of waste hauler that services facility:

F. Name of waste hauler that services facility for contaminated waste and sharps:

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**APPLICANT/BODY ART FACILITY LICENSEE STATEMENT OF CONSENT:**

*I understand that this registration expires on June 30 of this year. I understand that any notice required to be given by the Somerville Health Department to me may be given by mailing the notice to the address of the last place of business (facility address) of which I have notified the Somerville Health Department. I have received a copy of the City of Somerville Body Art Regulations. I agree to abide by these regulations and procedures. I agree to post the following valid and updated documents conspicuously in my place of business at all times:*

- *Original Licenses for Body Art Practitioners working in the facility, and*
- *Original License for Body Art Facility*

I authorize and release the Board of Health to seek information or references necessary to verify the information contained in this application:

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Signature of Applicant

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Date

I hereby certify under pains and penalties of perjury, that to the best of my knowledge, the information provided on this application is complete and accurate and not misrepresented in any way.

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Signature of Applicant

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Date**Office use only:****Facility Inspection Date:** \_\_\_\_\_**Inspector:** \_\_\_\_\_~ **Approved, Effective Date:** \_\_\_\_\_ **License #** \_\_\_\_\_**Fee Paid:** \_\_\_\_\_~ **Disapproved, Comment:** \_\_\_\_\_

## SUPPLEMENTAL INFORMATION

Body Art Establishment applicants must attach Supplemental Information pages for each partner or limited partner of applicant, if a partnership applicant, and each officer and director, if a corporate applicant, and any stockholder of a corporate applicant holding more than 10% of the stock of the corporate applicant with the following information:

Business Name: \_\_\_\_\_

Additional Individual's Full Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

No. Street

Town/City

State

Zip Code

Home Phone Number: \_\_\_\_\_ Business Phone Number: \_\_\_\_\_

Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

No. Street

Town/City

State

Zip Code

All residential addresses of individual for the past five (5) years:

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D.O.B.: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Proof of age (copy of birth certificate or driver's license) submitted: Yes \_\_\_\_\_ No \_\_\_\_\_

Two (2) front faced portrait photographs (2"x 2") within six (6) months submitted: Yes \_\_\_\_\_ No \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Former occupations or Body Art occupations of individual for past three (3) years:

**Occupation**

**Name of Business and Address**

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Have you had a license or permit to practice Body Art or conduct a Body Art Establishment suspended or revoked by any agency or board, city, county or state?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain:

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List all criminal convictions, forfeiture of bond, or plea of nolo contendere, excluding traffic, misdemeanor or infraction violations:

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I authorize and release the Board of Health to seek information or references necessary to verify the information contained in this application:

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

I certify under penalty of perjury that all information contained in this application is true and correct. Any misstatements in this application are grounds for refusing to issue or for revocation of any license issued.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

